



## CMS to Activate Advance Care Planning Codes

**Practitioner payment for CPT codes 99497 and 99498 effective January 1, 2016**

November 13, 2015 01:42 PM

On October 30, 2015, the Centers for Medicare & Medicaid Services (CMS) placed on public display the final rule governing Medicare Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2016, which includes information on payment for advance care planning (ACP). The Rule is scheduled to be published in the *Federal Register* on November 16. Previous *NAHC Report* coverage on the rule is available [here](#).

As part of the final rule, CMS announced its plans to move forward with activation of:

- **CPT code 99497** [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed) by the physician or other qualified health professional; first 30 minutes, face-to-face with the patient, family member(s) and/or surrogate] ; and
- An add-on **CPT code 99498**, [Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health professional; each additional 30 minutes (List separately in addition to code for primary procedure)].

These activities may be billed on the same day or on a different day from billing of other Evaluation and Management (E&M) services, but may not be billed on the same date of service as certain critical care services including neonatal and pediatric critical care.

Following is information provided by CMS in response to numerous comments on the proposal to active the ACP codes beginning January 1, 2016:

**Providers of ACP:** While CMS recognizes the role of other providers in the provision of ACP services (such as social workers, chaplains, and others), CMS notes that CPT code descriptors describe services furnished by physician or other qualified professionals, which for Medicare purposes is consistent with allowing these codes to be billed by the physicians and non-physician practitioners (NPPs) whose scope of practice and Medicare benefit category include the services described by the CPT codes and who are authorized to independently bill Medicare for those services. Therefore only these practitioners may report these CPT codes. As a physician service, CMS notes that “incident to” rules apply when these services are furnished incident to the services of the billing practitioner, which includes a minimum of direct supervision. CMS expects the billing physician or NPP to manage, participate and meaningfully contribute to the provision of the services. CMS also notes that the usual PFS payment rules regarding “incident to” services apply, so that all applicable state law and scope of practice requirements must be met in order to bill ACP

services. CMS does not believe it would be appropriate to create an exception to allow these services to be furnished incident to a physician or NPP's professional services under less than direct supervision.

**Relative Value Units (RVUs):** Activation of the codes means that these codes will be separately payable under the Physician Fee Schedule (PFS) and that they are assigned work relative value units (RVUs) of 1.5 (99497) and 1.4 (99498).

**National Coverage Determination:** While CMS will evaluate whether a national coverage determination should be developed for this service, CMS believes that it may be advantageous to allow time for implementation and experience with ACP services before considering such, so for the time being the contractors will be responsible for local coverage decisions.

**Location of Services:** ACP services are appropriately furnished in a variety of settings, and are separately payable to the billing physician or practitioner in both facility and non-facility settings and are not limited to particular physician specialties. CMS has also provided for payment of ACP services to hospitals when such services are provided in an outpatient department under the CY2016 hospital outpatient prospective payment system final rule.

**Part of Annual Wellness Visit (AWV):** CMS requested comment in the proposed physician payment rule as to whether ACP services should be billable as part of the AWV. In the final rule, CMS has added ACP as a voluntary, separately payable element of the AWV. CMS instructs that when ACP is offered as part of the AWV as part of the same visit on the same date of service and the parameters for billing the ACP CPT codes are met (including the requirements for the duration of the ACP services), the appropriate ACP code(s) should be reported and should be reported with the modifier -33 so that there will be no Part B coinsurance or deductible charged (as is consistent with the AWV).

**Training:** Many individuals commenting on the proposal to active the ACP codes recommended that CMS establish standards or require specialized training as a condition of payment for ACP services. CMS responded that since the ACP CPT codes describe face-to-face services, they don't believe it is appropriate at this time to apply additional payment standards, but CMS will continue to consider whether such are appropriate.

**Beneficiary Cost-sharing:** While a number of commenters recommended that CMS waive beneficiary cost-sharing for ACP services, CMS does not have statutory authority at this time to do so. CMS does recommend that practitioners inform beneficiaries of the voluntary nature of ACP services and also that ACP service will be subject to separate cost sharing (except as part of the AWV).

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